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ABSTRACT

With controlled drinking increasingly recognized as a viable treatment goal, there is a clear need for the development of reliable, valid procedures to assess alcoholics' preferences for and success in treatment programs striving to achieve either abstinence or controlled drinking. The purpose of this study is to answer three questions: (1) What differences, if any, exist between alcoholics who select abstinence and those who select controlled drinking as a treatment goal? (2) What differences, if any, exist between alcoholics who are spurious and those who are motivated treatment candidates? (3) What percentage of spurious treatment candidates are among male veteran alcoholics hospitalized for detoxification? Conclusions drawn from this study are that: (1) the assessment battery proved useful in providing information about motivation for treatment but not about treatment goal; (2) those who are unmotivated for treatment have similar characteristics whether they select abstinence or controlled drinking as a goal; (3) subjective distress is apparently a chief determinant of motivation for treatment; (4) field dependence is a measure which may prove useful in detection of denial problems and/or lack of candor, and (5) while the assessment battery proved useful as a screening device, the need for careful behavioral assessment, including gathering information from collateral sources, is clearly indicated. (Author/LEB)

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PROBLEM PERCEPTION, SELF-MANAGEMENT, AND PATIENT CHARACTERISTICS: ASSESSMENT OF TREATMENT PREFERENCE[1]

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As Roitzsch, Kilpatrick, White, Keeler, Miller, and Gilbert (1975) concluded in a recent review, there is considerable variability among alcoholics regarding their motivation to change maladaptive drinking behaviors, their degree of disruptive behavior resultant from problem drinking, and their environmental systems of support for changing maladaptive drinking patterns. Therefore, Kilpatrick and Roitzsch (1976) have argued that a chief thrust of behavioral treatment efforts should be to match alcoholics to the treatment programs which are most appropriate to their particular treatment needs and goals. Obviously, adoption of this strategy necessitates expanded assessment and evaluation efforts if there is to be any real effort to select the most appropriate treatment program for each alcoholic. It also follows that such a strategy dictates making available more than one kind of treatment.

Fortunately, treatment options have undergone considerable expansion during the past few years, and perhaps the most significant change is the addition of controlled drinking as a treatment goal. Initiated by the report of Davies (1962), the controversy over the appropriateness of controlled drinking as a treatment goal for alcoholics still rages, but the fact that at least some chronic alcoholics can learn to drink in a controlled fashion has been documented in reports by Lovibond and Caddy (1970), Marlatt (1975), Nathan (1973), Roitzsch and Kilpatrick (1973), Sobell and

Sobell (1973), Staples (1976), and the recent Rand Corporation Report (Armor, Polich, & Stambul, 1976). With controlled drinking increasingly recognized as a viable treatment goal, there is a clear need for the development of reliable, valid procedures to assess alcoholics' preference for and success in treatment programs striving to achieve either abstinence or controlled drinking (Briddell & Nathan, 1976; Miller & Caddy, 1977).

Perhaps the simplest approach used to assess treatment goal preference is to ask the client to select either abstinence or controlled drinking as his or her treatment goal. Using this approach, Sobell, Sobell, and Christelman (1972) found that many alcoholics reported a preference for controlled drinking as a treatment goal. Kilpatrick et al. (1976), in a pilot study for the present investigation, found that 56% of a sample of 38 hospitalized male alcoholics selected controlled drinking as a treatment goal. Miller and Caddy (1977) wisely suggest that one guideline for treatment goal selection be a stated preference for that goal by the alcoholic.

However, selection of a treatment goal by the client may be a necessary but not sufficient condition for assignment to treatment. Miller and Caddy (1977) reviewed several other variables to be considered in the assessment of treatment goal process. Additionally, Kilpatrick et al. (1976) found disturbing evidence that some clients who select controlled drinking as a goal may do so out of attempts to deny the severity of their drinking problems and to maintain the illusion that their drinking behavior is under control. Calling such individuals "spurious controlled drinking

candidates," Kilpatrick et al. (1976) stated that they are characterized by: (1) a stated preference for controlled drinking as a goal, (2) a failure to admit to any problem controlling their alcohol consumption even when hospitalized for detoxification, and (3) failure to agree to participate in a treatment program designed to teach controlled drinking skills. Such "spurious controlled drinking candidates," it was argued, probably make poor candidates for controlled drinking programs since they fail to believe that their drinking is out of control and to perceive the need for their participation in a treatment program.

The Kilpatrick et al. (1976) study did not address this issue, but it is apparent there are also clients among those who select abstinence with similar characteristics of denial of problem drinking and refusal to participate in a treatment program which promotes abstinence. Such individuals might be called "spurious abstinence candidates," and their identification might also be an important goal of assessment. While only carefully conducted outcome research can ultimately determine which candidates are most appropriate for abstinence or controlled drinking programs, it is reasonable to assume that the "spurious treatment candidates" who neither admit problem drinking nor perceive a need for treatment will experience less benefit from treatment than their counterparts who more realistically assess problematic drinking and need for treatment.

From this review, it follows that, prior to treatment, it is important to assess: (1) whether the client's goal for treatment is abstinence or controlled drinking, and (2) whether the client is a spurious or motivated treatment candidate. However, there is

scant available data regarding the characteristics of clients who differ on these treatment goal preference and legitimacy of treatment candidacy variables. Thus, the purpose of the present study is to attempt to answer three questions:

1. What differences, if any, exist between alcoholics who select abstinence and those who select controlled drinking as a treatment goal?

2. What differences, if any, exist between alcoholics who are spurious and those who are motivated treatment candidates?

3. What percentage of spurious treatment candidates are among male veteran alcoholics hospitalized for detoxification?

Method

Subjects: Participants in this investigation consisted of 154 chronic male alcoholics who were admitted to the Charleston, South Carolina, Veterans Administration Hospital Substance Abuse Treatment Ward for detoxification. The operations of this ward are described in greater detail elsewhere (Roitzsch, Kilpatrick, White, Keeler, Miller, & Gilbert, 1975), but, in summary, it provides detoxification services as well as short-term treatment for alcohol and drug-related problems. The demand for treatment is considerable, there existing a constant waiting list, so all veterans admitted must have a substantial need for detoxification and other treatment. All study participants were gamma-type alcoholics whose alcohol-related problems had existed for several years.

Assessment Battery: In addition to medical and behavioral evaluation, a battery of assessment instruments has been compiled. This battery includes a detailed structured interview, the rod and frame test, and a series of objective psychometric instruments which measure a variety of mood states and personality variables. The structured interview gathers information regarding biographical and demographic variables, history of alcohol abuse, self-appraisal of problem drinking, goals for treatment (controlled drinking or abstinence), and willingness to participate in several treatment programs for maladaptive drinking. The field dependence or independence of the subjects is evaluated via the use of a portable rod and frame apparatus, and scores are reported as deviations from the vertical in degrees.

The battery of psychometric instruments included the following tests briefly described:

1. The Eysenck Personality Inventory, EPI (Eysenck & Eysenck, 1968) which measures two basic personality types or dimensions, that of introversion-extraversion and stability-neuroticism;

2. The Minnesota Multiphasic Personality Inventory, MMPI (Hathaway & McKinley, 1940);

3. The Profile of Mood States Scale, POMS (McNair, Lorr, & Droppleman, 1971) which measures six factor-analytically derived dimensions of tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia, and confusion-bewilderment;

4. The Rokeach Dogmatism Scale (Rokeach, 1960), a measure of open and closed mindedness;

5. The Locus of Control Scale (Rotter, 1966), a measure of the extent to which an individual believes that environmental events and rewards are contingent upon his own behavior;

6. The Spielberger State-Trait Anxiety Inventory, STAI (Spielberger, Gorsuch, & Lushene, 1970), a self-report measure of state anxiety (A-state) and trait anxiety (A-trait);

7. The Wolpe-Lang Fear Survey Schedule III (Wolpe & Lang, 1964), which consists of items and situations empirically determined to be disturbing to behavior therapy patients, including six basic subscales of animal fears, tissue damage fears, classical fears, social-interpersonal fears, miscellaneous fears, and failure/loss of self-esteem fears; and

8. The Zuckerman Sensation Seeking Scale IV (Zuckerman, 1971), which measures the degree to which an individual seeks out varied, novel, or complex situations or experiences and yields five factors of boredom susceptibility, disinhibition, experience seeking, thrill and adventure seeking, and a general scale.

Procedure. Between four and seven days after admission, all subjects completed the assessment procedures. On the basis of responses given in the clinical interview regarding their preference for a treatment goal, subjects were classified into an Abstinence Goal Group (n=97) or a Controlled Drinking Goal Group (n=57). Each subject was then asked this question: "Do you think you have (or have had) a problem controlling your drinking alcohol?" Those chronic alcoholics presently hospitalized for alcohol detoxification who responded affirmatively to that question were operationally defined as being motivated for treatment since they admitted that they were aware that they had problems controlling their drinking behavior and had applied to the hospital for treatment. Those who responded negatively to the question about problem drinking were operationally defined as spurious treatment candidates since they denied any problem in controlling their alcohol consumption. Using this definition of motivation for treatment, 132 of the subjects were classified as motivated, while 22 subjects denied problems controlling alcohol consumption and were classified as spurious treatment candidates.

Subjects were then classified into one of the following four groups:

1. Abstinence Goal - Motivated for Treatment (Abstinence-Motivated, n=86),

2. Abstinence Goal - Spurious Treatment Candidate (Abstinence-Spurious, n=11),
3. Controlled Drinking Goal - Motivated for Treatment (Controlled Drinking-Motivated, n=46), and
4. Controlled Drinking - Spurious Treatment Candidate (Controlled Drinking-Spurious, n=11).

The demographic variables of mean age and years of education of the four groups were analyzed in separate 2(Treatment Goal) x 2(Motivation for Treatment) analyses of variance. Scores of the four groups on each test battery variable were also analyzed in series of forty-two 2(Treatment Goal) x 2(Motivation for Treatment) analyses of variance.

Results

The groups ranged in mean age from 45.18 years for the Abstinence-Spurious Group to 48.36 years for the Controlled Drinking-Spurious Group, but differences in age were not significant for treatment goal ($F=.43$; $p>.1$), motivation for treatment ($F=.30$; $p>.1$), or for the interaction between these variables ($F=.72$, $p>.1$). Similarly, there were no significant differences among groups with respect to years of education, which ranged from 10.64 years for the Controlled Drinking-Spurious Group to 11.82 years for the Abstinence-Spurious Group.

Inspection of the results of the 42 separate analyses of variance conducted on the test battery variables revealed that there were no main effects due to the independent variable of treatment goal. Thus,on none of the 42 dependent variables in the test battery were there significant differences between

subjects selecting abstinence as a treatment goal and those selecting controlled drinking. Neither were significant interactions observed between the treatment goal and motivation for treatment variables for 41 of the 42 dependent variables. Only on the experience seeking subscale of the Zuckerman Sensation Seeking Scale was a significant interactor observed ($F=4.41$, $df=1/141$, $p < .05$) between the two independent variables. Since only one out of 84 possible comparisons involving the treatment goal variable yielded significant results, a rate less than the 4.2 significant results which might have been expected to have occurred by chance at the $p < .05$ level, these results suggest that no differences on the test battery variables existed between those who preferred abstinence and those who preferred controlled drinking as a treatment goal.

In contrast to these negative findings regarding the treatment goal preference variable, many significant differences occurred as a function of the motivation for treatment variable. Presented in Figure 1 are the mean MMPI profiles of the Spurious and Motivated for Treatment groups.

Insert Figure 1 about here

Subjects in the Motivated for Treatment group had significantly lower mean scores on the Lie ($F=5.83$; $p < .025$) and significantly higher scores on the Depression ($F=7.84$; $p < .01$), MF ($F=4.06$; $p < .05$), and Psychasthenia ($F=6.27$; $p < .025$) subscales. Differences on the other MMPI subscales failed to achieve statistical significance.

In Table 1 are presented the mean neuroticism, anxiety,

Insert Table 1 about here

and fear scores of the four groups. The members of the combined Motivated for Treatment groups had significantly higher neuroticism ($F=4.39$; $p<.05$), A-state ($F=3.64$; $p<.05$), and A-trait ($F=6.34$; $p<.025$) scores than members of the Spurious Treatment groups. On the subscales of the Fear Survey Schedule, there were no differences on the animal ($F=.04$; $p>.1$), tissue damage ($F=2.70$; $p>.1$), or classical ($F=1.64$; $p>.1$) fear scales. However, the Spurious Treatment groups had significantly lower social-interpersonal ($F=6.74$; $p<.025$), miscellaneous ($F=6.93$; $p<.01$), failure-loss of self-esteem ($F=11.51$, $p<.001$), and total ($F=4.78$; $p<.05$) fear scores.

With respect to the mean dogmatism, locus of control, extraversion, EPI lie, and field dependence scores included in Table 2, significant differences between the Motivated for Treatment

Insert Table 2 about here

and Spurious Treatment groups were observed only in field dependence ($F=3.27$; $p<.05$), where the latter group was more field dependent than the former. No differences were observed in dogmatism ($F=2.29$; $p>.1$), locus of control ($F=.65$; $p>.1$), extraversion ($F=.01$; $p>.1$), and EPI lie ($F=.89$; $p>.1$) scores.

With the exception of the experience seeking subscale data which have been previously discussed, inspection of Table 3

Insert Table 3 about here

reveals that no significant differences between motivation for treatment groups on the boredom susceptibility ($F=2.08$; $p>.1$), disinhibition ($F=1.71$; $p>.1$), thrill and adventure seeking ($F=.32$; $p>.1$), and general ($F=.72$; $p>.1$) sensation seeking subscales.

Examination of the mood state profiles of the two Treatment Motivation groups presented in Figure 2 indicates that members of Motivated for Treatment groups had significantly higher

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Insert Figure 2 about here

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tension-anxiety ($F=14.07$; $p<.001$), depression-dejection ($F=15.91$; $p<.001$), fatigue-inertia ($F=12.52$; $p<.001$), and confusion-bewilderment ($F=17.85$; $p<.001$) scores and significantly lower scores on the vigor-activity ($F=5.73$; $p<.025$) mood state than their spurious treatment counterparts. No significant differences were observed on the mood state of anger-hostility ($F=2.15$; $p>.1$).

Examination of the numbers of alcoholics classified into the four treatment goal x motivation for treatment categories yielded the following information. Sixty-three percent of these men selected abstinence as a treatment goal. Of the 63 percent selecting abstinence, 11.3 percent were spurious treatment candidates. A total of 37 percent of the sample selected controlled drinking, and, of these, 19.3 percent were identified as spurious candidates. Thus, of the total sample, 14 percent were classified as spurious treatment candidates.

A final set of analyses compared the self-reported drinking-related problem behaviors of the four groups. These data,

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Insert Table 4 about here

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presented in Table 4, revealed no significant differences among groups as a function of treatment goal on any of the problems. However, the combined Spurious Treatment groups had significantly lower percentages of individuals who had:

(1) lost or changed jobs because of drinking ($p < .01$),

(2) drank early in the morning to get going ($p < .01$), and

(3) drank during the day to keep going $p < .01$).

Spurious treatment candidates also reported significantly fewer hospitalizations for alcohol-related problems than motivated for treatment candidates ($p < .01$).

Discussion

Several interesting findings emerged from the present investigation, but perhaps the most surprising single finding was the failure to discover any differences among alcoholics as a function of their treatment goal. Veterans aspiring to a goal of controlled drinking did not differ from their abstinence-desiring counterparts in age, education, personality traits, subjective mood state at the time of hospital admission, field dependence, or in frequency of self-reported indices of problem drinking. Given the comprehensiveness of the assessment battery administered to these alcoholics, it appears that such traditional

assessment approaches show little promise in promoting an understanding of differences between those who select abstinence and those who select controlled drinking. Perhaps use of behavioral assessment techniques as described by Briddell and Nathan (1976), which involve direct observations of drinking behavior, social interaction patterns, and techniques for coping with stress, would be more productive.

The question of whether spurious and motivated treatment candidates would differ on relevant variables was answered affirmatively. While no differences were found with respect to age or education, motivated treatment candidates were significantly different from the spurious treatment candidates on 18 of the 42 assessment battery variables and on four of the six self-report indices of alcohol-related problem behaviors. Contrary to intuitive expectations that spurious treatment candidates, who, it must be remembered, were hospitalized for detoxification, would exhibit greater pathology on the self-report measures, they proved to be less disturbed. The most striking and consistent differences occurred on the measures of fear, anxiety, depression, and subjective mood state. Alcoholics motivated for treatment either actually experienced or reported more subjective distress than alcoholics who were spurious treatment candidates. Only on the MMPI Lie scale and the rod and frame measure of field dependency did the spurious candidates appear to be more pathological or disturbed than those motivated for treatment.

One finding is clear and irrefutable; alcoholics, be they advocates of controlled drinking or abstinence, who are willing

to participate in treatment for their problem drinking report themselves to be experiencing considerable subjective distress. They report themselves to be high in A-trait, high in A-state at the time of testing, high in emotional liability as measured by the Eysenck neuroticism scale, higher in social-interpersonal, miscellaneous, and failure-loss of self-esteem fears, higher on the MMPI psychasthenia scale which contains a large anxiety component, and higher on the mood state measure of tension-anxiety. These anxiety findings support those reported by Kilpatrick, Sutker, and Smith (1976) in a recent review of the role of anxiety in alcoholism and tend to refute those who have stated that anxiety reduction plays no part in alcoholism (e.g., Cappell & Herman, 1972). Moreover, individuals motivated for treatment also exhibited greater depression as measured by the MMPI and mood disturbances of depression-dejection, fatigue-inertia, and confusion-bewilderment as well as less vigor-activity as measured by the Profile of Mood States scale. Whether their subjective distress is real or is the result of an increased willingness to admit to psychopathology remains unclear, however. A greater percentage of these patients reported drinking-related problems as well, and they also reported a greater number of hospitalizations for alcohol-related problems. Of course, we still don't know whether they actually have more problems or just admit to more problems. The need for accurate, objective assessment of such problem behaviors seems apparent.

Turning to the spurious treatment candidates, we are faced with some difficulties as we attempt to interpret their data.

Do they actually experience less subjective distress, or do they experience distress but fail to report it? Are their drinking-related problems actually less severe than those who want treatment, or do the spurious candidates fail to report the extent of their problematic drinking? Alternatively, if their drinking-related problems are as severe and they fail to appreciate the magnitude of such problems, their low self-report of problems could reflect lack of awareness and denial rather than lack of candor. These questions cannot be answered definitively, but there are data which suggest that spurious treatment candidates are not problem free. First, their higher lie scores on the MMPI might be interpreted as reflecting a general lack of candor. Secondly, they scored as more field dependent than those who wanted treatment. That alcoholics are field dependent has long been noted, although whether field dependency reflects "passivity in dealing with the environment and lack of self-esteem" as suggested by Witkin, Karp, and Goodenough (1959), covert dependency as suggested by Blane and Chafetz (1971), or some biological substrate of behavior as might be surmised from the work of Harley, Cohen, and Silverman (1974) remains unclear. However one chooses to interpret the meaning of field dependence, there is general agreement that it is a pathological characteristic. It is also important to note that the rod and frame test of field dependence is a relatively unobtrusive measure which is difficult to "fake" since it is unclear to the subject what is being tested or how one should score to "look good." The fact that spurious candidates were extremely field dependent argues against the

hypothesis that they are well-adjusted and problem free.

Thirdly, in spite of the fact that they reported fewer alcohol-related problems, the spurious candidates still had significant drinking problems as evidenced by the fact that 47.75% admitted to alcoholic blackouts, and 25% had experienced DTs. All spurious candidates were hospitalized for detoxification, and between one-third and one-half of this group admitted to previous hospitalizations for alcohol-related problems. Thus, all members of this group had significant drinking problems.

In combination, these facts appear to rule out the possibility that spurious treatment candidates do not want treatment because they are problem free. However, the need for accurate assessment of the extent of problematic behavior among these individuals is particularly apparent.

What conclusions can be drawn from the present study? First, the assessment battery proved useful in providing information about motivation for treatment but not about treatment goal. Second, findings indicated that those who are unmotivated for treatment have similar characteristics whether they select abstinence or controlled drinking as a goal. Third, subjective distress is apparently a chief determinant of motivation for treatment. Fourth, field dependence is a measure which may prove useful in detection of denial of problems and/or lack of candor. Finally, while the assessment battery proved useful as a screening device, the need for careful behavioral assessment, including gathering information from collateral sources, is clearly indicated.

Footnote

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Table 1

Mean and Standard Deviation ( ) Anxiety, Fear, and Neuroticism Scores of Spurious and Motivated for Treatment Abstinence and Controlled Drinking Groups

Personality Variable	Abstinence-Motivated	Ccntrolled Drinking-Motivated	Abstinence-Spurious	Controlled Drinking-Spurious
EPI - Neuroticism	13.98 (6.34)	12.95 (5.15)	8.75 (2.49)	11.33* (4.08)
STAI				
A-state	51.41 (14.41)	50.17 (10.24)	36.60 (9.7)	42.8* (11.75)
A trait	50.02 (12.61)	48.58 (9.99)	38.20 (6.19)	43.60* (9.02)
FSS III				
Total	157.23 (37.62)	155.16 (36.63)	133.62 (28.36)	132.83* (30.55)
Animal	14.36 (5.20)	13.69 (4.19)	12.37 (2.26)	14.00 (3.58)
Tissue Damage	40.51 (10.48)	40.74 (10.64)	34.50 (11.3)	36.50 (13.10)
Classical	27.66 (9.41)	26.67 (8.08)	24.37 (5.26)	23.67 (5.39)
Social-Interpersonal	39.06 (11.06)	38.46 (8.47)	32.25 (8.79)	30.50* (9.67)
Miscellaneous	27.21 (7.11)	26.81 (6.70)	22.62 (6.36)	21.00** (5.10)
Failure - Loss of Self-Esteem	44.06 (13.54)	43.11 (9.74)	34.00 (7.05)	30.5*** (10.09)

* $p < .05$

** $p < .01$

*** $p < .001$

Table 2

Mean and Standard Deviation ( ) Dogmatism, Locus of Control, EPI, and Field Dependence Scores of Spurious and Motivated for Treatment Abstinence and Controlled Drinking Groups

Personality Variable	Abstinence-Motivated	Controlled Drinking-Motivated	Abstinence-Spurious	Controlled Drinking-Spurious
Dogmatism	168.92 (30.67)	167.27 (32.48)	162.62 (16.85)	187.33 (18.71)
Locus of Control	6.86 (3.86)	7.69 (4.05)	8.50 (2.32)	7.83 (4.02)
EPI-extraversion	10.95 (4.31)	12.09 (3.98)	11.12 (3.04)	11.67 (3.83)
EPI - lie	2.83 (1.76)	2.53 (1.84)	3.87 (1.45)	2.67 (1.37)
Field Dependence	9.14 (6.03)	9.79 (6.64)	12.87 (9.19)	12.82* (5.48)

* $p < .05$

Table 3

Mean and Standard Deviation ( ) Sensation Seeking Scale Scores of Spurious and Motivated for Treatment Abstinence and Controlled Drinking Groups

Personality Variable	Abstinence-Motivated	Controlled Drinking-Motivated	Abstinence-Spurious	Controlled Drinking-Spurious
SSS				
Boredom Susceptibility	5.19 (2.40)	5.48 (2.55)	4.40 (3.83)	4.44 (2.35)
Disinhibition	4.51 (3.10)	4.98 (2.65)	4.3 (2.26)	3.33 (2.24)
Experience Seeking	3.95 (3.13)	4.67 (3.57)	5.50 (2.41)	3.00* (2.18)
Thrill & Adventure Seeking	5.61 (3.69)	5.59 (2.90)	5.60 (3.02)	4.67 (3.12)
General	6.96 (3.99)	7.00 (3.34)	7.10 (3.81)	5.11 (1.90)

* $p < .05$

Table 4

Percentage of Spurious and Motivated for Treatment Abstinence and Controlled Drinking Groups Experiencing Drinking-Related Problems (Self-Report)

Drinking Problem	Abstinence-Motivated	Controlled Drinking-Motivated	Abstinence-Spurious	Controlled Drinking-Spurious
Experienced Blackouts	60.0	65.2	45.5	50.0
Experienced DTs	34.1	35.6	27.3	22.2
Lost or Changed Jobs	51.8	54.3	18.2	9.1
Early Morning Drinking	83.3	76.1	45.5	45.5
Drinking to "Keep Going"	83.3	64.4	50.0	36.4
No. of Hospitalizations	2.89	3.48	1.46	1.36

* Significant difference ($p < .01$) between percentages of Spurious Treatment and Motivated for Treatment Groups

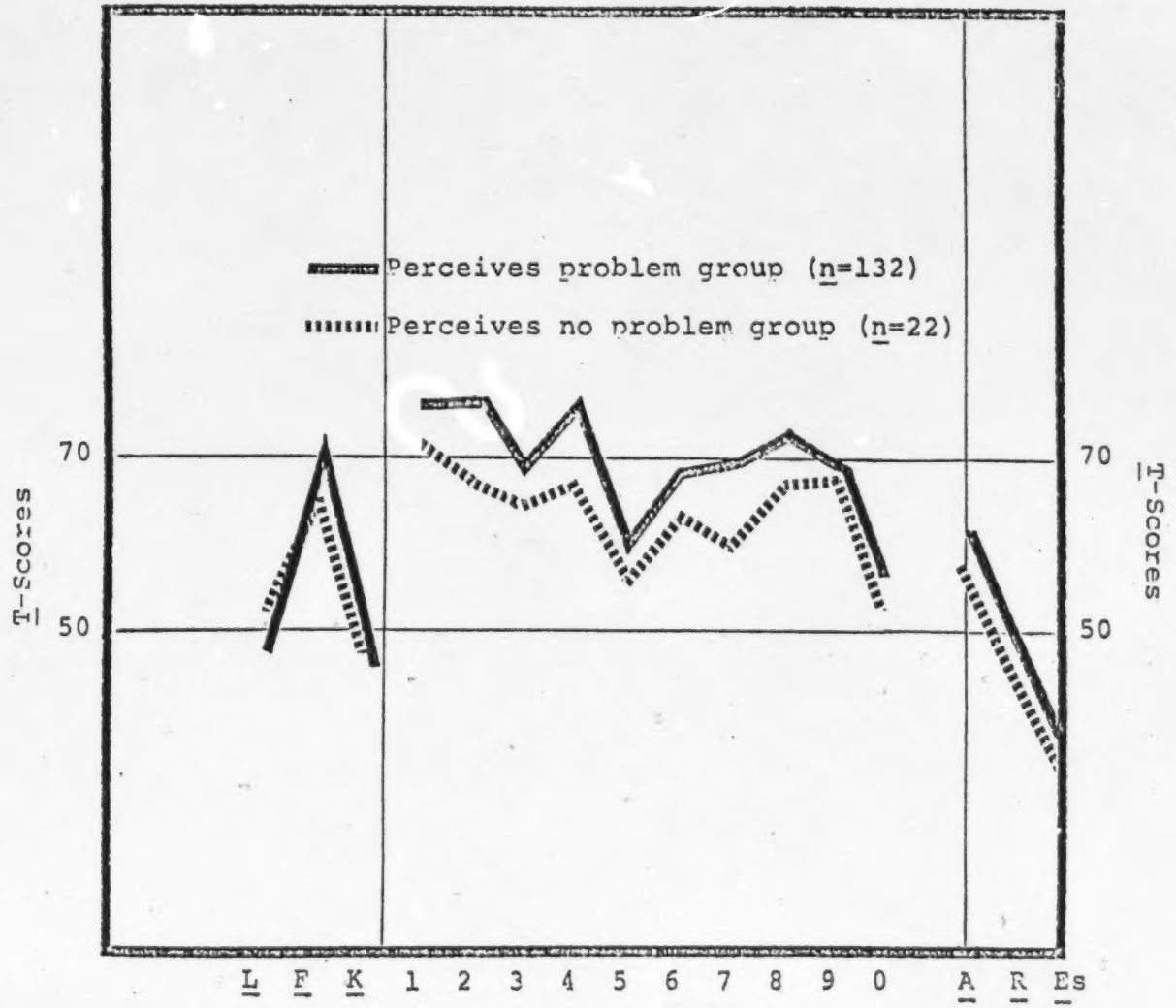

Figure 1. Mean MMPI profiles of perceives no problem and perceives problem groups.

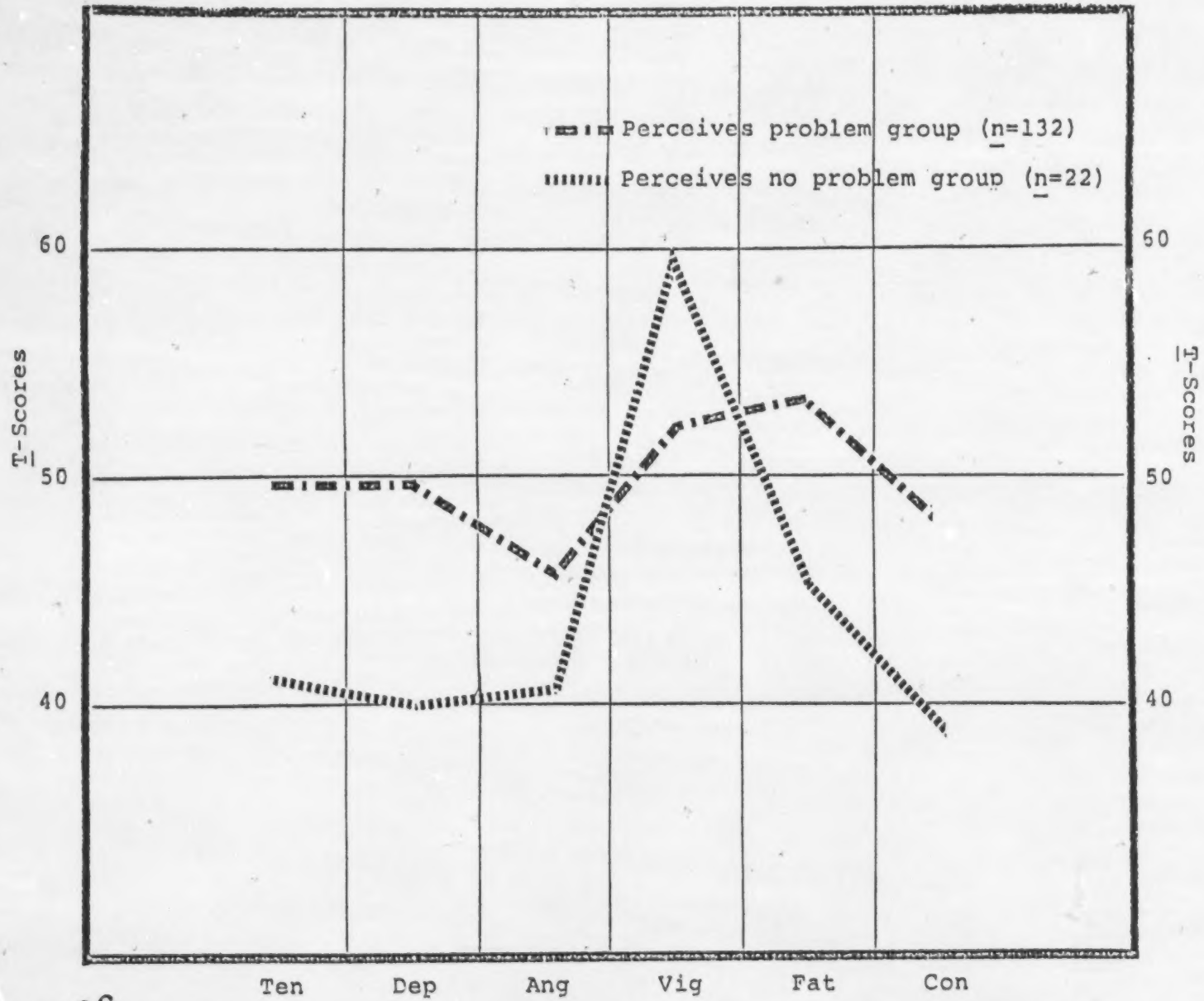

Figure 2. Mean Profile of Mood State scores of perceives no problem and perceives problem groups.

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